Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTH CENTRAL SURGICAL CENTER
9301 N CENTRAL EXPWY #100
DALLAS TX 75231

Respondent Name
CITY OF DALLAS

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-13-0564-01

MFDR Date Received
OCTOBER 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…We are requesting 108% of Medicare DRG with implant consideration for an allowed amount of $20,247.48; less the payment received of $12,458.26; we are rightfully owed $7,789.22."

Amount in Dispute: $7,267.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the Medical Dispute Resolution DWC 60 concerning claimant [injured worker] from North Central Surgical Hospital for dates of service 6/16-6/22/12. Based on our research we find the documentation presented for additional reimbursement is inconsistent with the bill reviewed … Therefore it is our position that no further recommendation is warranted."

Response Submitted by: IMO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2012 through June 22, 2012	Inpatient Hospital Surgical Services	$7,267.74	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 03, 2012

- 222 – Charge exceeds Fee Schedule allowance
- 942 – Incomplete billing info or support documentation. Charge will be evaluated upon receipt
- 993 – Reduction is based on the Inpatient Fee Schedule
- ANSI16 16 – Claim/service lacks information which is needed for adjudication
- ANSIW1 W1 – Workers Compensation Jurisdictional Fee Schedule Adjustment

Explanation of benefits dated October 03, 2012

- 222 – Charge exceeds Fee Schedule allowance
- 380- Recommendation is based on attached invoice
- ANSI18 18 – Duplicate claim/service
- ANSI193 193 – Original payment decision is being maintained. This claim was processed properly the first time
- ANSIB13 B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- ANSIW1 W1 – Workers Compensation Jurisdictional Fee Schedule Adjustment

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	Joint Device (Implantable)	Piton Knotless Fixation Implant Size 3,5 mm Suture Bleu/Blanc	1 at $395.00 ea	$395.00	$434.50

$395.00	$434.50
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is 470, and that the services were provided at NORTH CENTRAL SURGICAL CENTER. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $11,492.89. This amount multiplied by 108% results in an allowable of $12,412.32.
   - The total cost for implantables from the table above is $395.00. The sum of the per-billed-item add-ons does not exceed the $2000 allowed by rule; for that reason, total allowable amount for implantables is $395.00 plus $39.50, which equals $434.50.

   Therefore, the total allowable reimbursement for the services in dispute is $12,412.32 plus $434.50, which equals $12,846.82. The respondent issued payment in the amount of $13,607.76. Based upon the documentation submitted no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	4/26/13 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.